At Carolinas Rehabilitation, we have a simple mandate to make no compromises in our commitment to care.

Carolinas Rehabilitation provides the full continuum of care, from acute inpatient rehabilitation to extensive outpatient physician and therapy services. Our ties with Carolinas HealthCare System give us access to other services—home healthcare, skilled nursing facilities, state-of-the-art technology, expert physicians—which allows us to provide an exceptional level of care to our patients. But we’re not content to just give the best rehab care possible—we’re intent on redefining best practices in our field.

A SYSTEM ON THE MOVE

We’re working toward our mandate in many ways, and here are some you’ll learn about in this issue of Within Your Reach:

• We’re identifying new ways to improve quality of care and safety throughout our system. A new Hand-Off Protocol (HOP) in our falls prevention program reduced the falls rate in our four hospitals by more than 25 percent in 2012. We want to be a leader in defining and improving quality measures that are specific to inpatient rehabilitation.

• We’re taking our best research and clinical innovations to peers—hosting events such as the October 2012 regional conference on traumatic brain injury/spinal cord injury that brings together clinicians from institutions in North and South Carolina, and through EQUADR™ (Exchanged Quality Data for Rehabilitation), a quality network we created that connects inpatient rehab facilities nationwide. The EQUADR™ network helps us share information, ideas and best practices with peer institutions to drive quality improvement and increase the safety of inpatient services for rehab patients at our facilities and elsewhere.

• We’re bringing the best technology to patient care, such as the ReWalk™ system exoskeleton that helps patients with paralysis or paresis learn to walk again. We’re also committed to supporting our clinical researchers, such as Mark Hirsch, PhD. We welcome a new research director, Janet Niemier, PhD, who will promote ongoing innovation at Carolinas Rehabilitation through research.

• In 2013, we’re opening two new hospitals in Charlotte’s neighboring communities of Pineville and Concord, adding jobs and providing comprehensive services to rehab patients. These facilities will enable family members to be closer to their loved ones and more involved in the rehab process—an essential component of a patient’s successful recovery.

ENHANCING QUALITY OF LIFE

We’re always seeking ways to work more efficiently, effectively and compassionately. We take this mandate to heart because every innovation and improvement we make is not only an advancement of our program, but also a real enhancement in the health and well-being of a patient who’s suffered a life-changing event.

Sincerely,

WILLIAM BOCKENEK, MD
Medical Director, Carolinas Rehabilitation
Chairman, Physical Medicine and Rehabilitation
Quality reporting is nothing new for inpatient acute care but, until now, it wasn’t part of the inpatient rehab world. That changed on Oct. 1, 2012, when Medicare began requiring quality reporting for inpatient rehabilitation. Failure to report will mean a 2 percent reduction in reimbursements for 2014, so this is an important issue for hospitals. And although for now the reimbursement structure is only based on reporting, there’s every indication that, in the future, Medicare reimbursements for inpatient rehab services will be based on performance.

WHAT DOES THIS MEAN FOR PHYSICIANS?
For inpatient rehab, the reporting currently requires only two measures:
• pressure ulcers
• catheter-associated urinary tract infections (UTIs)

UTIs are most often measured by infectious disease specialists, but physicians can play a critical role in reporting and classifying pressure ulcers, whether they know it or not. The more clear, concise documentation of pressure ulcers you can give, the better. Clear documentation helps identify who the pressure ulcer “belongs to”—whether it developed at another facility or during the patient’s care on that physician’s service. If you have questions about best methods for documentation, speak to your medical coders or wound care experts for help.

WHAT’S AHEAD
Consensus in the rehab quality community is that these two measures are the first of many to come. The National Quality Forum (NQF) has already endorsed a list of additional measures for inpatient rehab, and Medicare is expected to give heavy weight to these recommendations. They could go into effect as early as 2014.

New NQF-endorsed measures include:
• incidence of potentially preventable venous thromboembolism (VTE)
• staff immunization
• percentage of short-stay patients who are admitted with a scheduled pain medication regimen and who self-report a decrease in pain intensity or frequency
• percent of patients who were assessed and appropriately given the seasonal influenza vaccine
• percent of patients who were assessed and appropriately given the pneumococcal vaccine

Two measures are still under development: functional outcomes and hospital readmissions. The latter was indicated as a measure of interest for current requirements, but it wasn’t implemented in the first wave because there were too many questions. Ultimately, it’s expected to be added and, when that happens, physicians will want to carefully monitor procedures for discharging patients from their service.

NEW PHYSICIAN RECEIVES PRESTIGIOUS AWARD

Obias Tsai, MD, a pediatric physiatrist who recently joined the staff at Carolinas Rehabilitation and Levine Children’s Hospital, received the 2012 Corbett Ryan Pathways Pioneer award from the American Academy for Cerebral Palsy and Developmental Medicine at the organization’s annual meeting in Toronto, Canada on Sept. 13.

Dr. Tsai was nominated by a colleague for:
• representing excellence in the pursuit of and quality of life
• being motivated and accomplishing personal and vocational/professional goals
• having a positive attitude and a creative approach to the pursuit of education
• serving as a role model and demonstrating sensitivity to others.

ABOUT THE AUTHOR: Suzanne Snyder, FACHE, MBA, PT, is on the board of directors for the American Medical Rehabilitation Providers Association and is co-chair of the association’s Quality Committee for inpatient rehabilitation. She frequently serves as a technical expert on many Medicare and MedPAC committees, as well as for the National Quality Forum, where she is scheduled to present in May 2013.
Research on political participation is a particularly timely topic, especially as a result of this year’s presidential elections and increased media attention on traumatic brain injury (TBI) due to reports of sports injuries and the prevalence of TBI among veterans. Recently, the Department of Defense initiated a pilot program to test voting technology for wounded warriors.

**RELATIONSHIP BETWEEN POLITICAL PARTICIPATION AND TBI**

The majority of U.S. states have constitutional language, statutes or court decisions that, if applied as worded, could bar individuals with TBI from voting. In an ongoing National Institutes of Health-funded study on voting, 55 individuals with moderate to severe TBI and 27 family members of individuals with TBI were followed to the polls in Mecklenburg County and interviewed about their experiences with voting during the 2007 general election and 2008 national presidential election. Responses to standardized tests of voting capacity and political literacy were evaluated by a research team from Carolinas Rehabilitation, Rutgers University, the University of Pennsylvania, Indiana University and the University of North Carolina at Charlotte. Individuals with TBI expressed the view that cognitive capacity to vote should not be a factor in voting but that “some people with high levels of cognitive impairment should not vote if they do not understand what is going on.” Individuals who chose not to vote were likely to list social stigma issues as the reason for not voting. African-Americans with TBI were statistically more likely than other groups to request cognitive help at the polls.

In a related study, the research team compared political knowledge of individuals with TBI to that of “average” college students who had taken an introductory course in political science at a large public university in North Carolina. Local political knowledge about the 2008 North Carolina election was assessed by administering a questionnaire asking about local party candidates and the overall workings of the American government—with questions taken from the United States Citizen and Immigration Services (USCIS) citizenship exam question bank. Results included:

- Individuals with TBI (≥ 6 months post-TBI; 38 males/17 females; range 19–75 years of age; 63 percent had voted) recalled less about the 2008 national presidential election and the USCIS than college students. (Participants with TBI scored an average of 4.2 out of 10 points on the USCIS, while college students scored an average of 6.6 out of 10 points on the USCIS.) On average, individuals in the TBI sample would not pass the citizenship test. The average score of the college students was barely passing, and 6 out of 22 did not pass the test.
- On the test of local political knowledge, individuals with TBI scored equal to the students on knowledge about the 2008 North Carolina election.

Neither gender, race, education, marital status, whether participants followed politics, or the amount of time since the election that the tests were administered were related to election knowledge or total political knowledge.

"IF INDIVIDUALS WITH TBI FAIL TO VOTE, THEY DON’T HAVE A VOICE IN THE FEDERAL AND STATE PROGRAMS, PRODUCTS AND SERVICES DESIGNED FOR THEM."

**TAKEAWAY:** If individuals with TBI fail to vote, they don’t have a voice in the federal and state programs, products and services designed for them. Unless measures are taken, this may disable democracy. Cognitive capacity-to-vote issues could be addressed in rehabilitative settings that may facilitate voting, political and civic participation. Rehabilitative centers can collaborate with patient advocacy and disability-rights groups, political scientists, economists and community associations to promote political participation. Strategies to address low voter participation and interventions to increase political participation are desperately needed.
To refer a patient to Carolinas Rehabilitation, call 1-877-REHAB51 (734-2251)

References:

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AFFILIATIONS:
1 – Carolinas Rehabilitation
2 – Mecklenburg County Board of Elections
3 – Indiana University
4 – University of Pennsylvania
5 – League of Women Voters of North Carolina, Charlotte Chapter
6 – University of North Carolina at Charlotte
7 – Rutgers University
8 – Disability Rights and Resources of Charlotte

CAROLINAS REHABILITATION SPONSORS TBI/SCI CONFERENCE

Advanced Rehabilitation Ideas for Traumatic Brain Injury (TBI) and Promoting Health and Wellness for Spinal Cord Injury (SCI) was held in Charlotte, on Oct. 15 and 16, 2012.

This multidisciplinary conference featured lecture and hands-on sessions offering current information for healthcare providers and students. “The conference shared evidence-based practices and advanced techniques for treating TBI/SCI patients,” says Lisa Hunt, OT, clinical coordinator of Outpatient Therapy at Carolinas Rehabilitation. “We wanted clinicians to be able to use these strategies and techniques in their day-to-day practices at their respective sites.”

WANT MORE?

To access resources from this conference, including the keynote address by Kevin Guskiewicz, PhD, visit carolinasherhabilitation.org/conferences.